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Dutch Case Studies Project in Chaplaincy Care. A description and theoretical explanation of the format and procedures

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Abstract

The recent surge of case studies in chaplaincy care raises challenges on the comparability of case studies and the degree to which they elucidate the relation between theory and practice. The Dutch Case Studies Project (CSP) addresses these and other issues by use of a set format and procedure and by evaluation in research communities of chaplains and academic researchers. We first place CSP in the context of Dutch chaplaincy and its recent history. The question of selection of a case for a case study then leads to a discussion of a number of methodological issues. That moves into an explanation of the following steps in the procedure: description, evaluation and finalization. Issues for further discussion and a conclusion complete the article.

Key words: Chaplaincy care, case studies, methodology, format, research communities

Introduction: Using a set format in research communities

Publications of case studies in chaplaincy care reveal that there is a lot more to chaplaincy than is often communicated. At the same time, different approaches to the description of case studies become evident, making comparison difficult (Fitchett & Nolan 2015; Swift, Cobb & Todd 2015; and various case studies in *Journal of Health Care Chaplaincy*; see also Brown 2010; Canada 2011). Especially the relation between theory and practice seems elusive. The use of theoretical models and concepts is hardly visible in the material. Also, most of the case

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studies presented are from the perspective of the individual chaplain, whereas there is a need for consensus building among chaplains and scholars as to what good practices in chaplaincy might be. That gives rise to two questions: (1) How can we effectively describe and evaluate practices of chaplaincy care through case studies? (2) How can we account for our procedures and research strategies?

The Dutch Case Studies Project in Chaplaincy Care (CSP) seeks to address these issues by working with a set format and a standard procedure in the context of research communities of experienced chaplains under the leadership of a research scholar (Körver 2016). The format is designed to elicit descriptions that help to answer to the central research question (or set of questions): ‘What do chaplains do, for what reasons and to what ends?’ Special attention is afforded to feedback from clients (or client systems) and from other professionals. The evaluations in research communities serve to elucidate the interventions of the chaplains and to explicate implicit theoretical considerations. The project takes both a specialized and a comparative approach by working with parallel research communities, most of which consist of chaplains from a specific setting of chaplaincy care (general hospitals, psychiatry, elderly care, military or prisons) and one of which is mixed (rehabilitation, primary care, juvenile care, care for those with learning disabilities, etc.).

Following brief comments on the context of the CSP in chaplaincy care, the four phases of the format will be presented and discussed.

Context: Professional Spiritual Care in the Netherlands

In the last decade of the previous century academic vocational programs in spiritual, i.e. chaplaincy care, were established in the Netherlands. On the one hand, those programs corresponded with a need of faculties of theology and religious study to provide an occupational perspective for their students in the face of the decrease of ecclesial positions. On the other hand, there was a drive to professionalize the practice of chaplaincy in the Netherlands in response to the challenges of standardization of healthcare. The move towards professionalization was long inhibited by the perception that standardization was at odds with the presence and person-centered care that chaplains want to provide (Mackor 2009). For some chaplains, there was a tension between their role as a representative of a world view tradition and their professional task to engage in spiritual communication with a broad public (Smeets & Morice-Calkhoven 2014). Gradually, the arguments used to legitimize the presence of

chaplaincy in the public domain have shifted from a paradigm based on religious freedom and endorsement of religious functionaries to an emphasis on the specific contribution of spiritual care professionals in those domains. The emphasis on professionalization subsequently presents a challenge to identify shared standards of chaplaincy practice, while at the same time explicating the differences of various contexts and of religious or world view backgrounds.

Gradually professional chaplains have become aware of the need for a research base for the profession. That is partially due to the pressure to create a research-based foundation for the profession in order to counter the tendency to reduce the number and size of chaplaincy positions. In addition, many chaplains, especially of the younger generation, have done academic, empirical work in the field during their education. That background likely contributes to the relatively high scores of chaplains in the Netherlands in an international study on attitudes toward research (Snowden et al, 2016).

Attitudes, however, are not the same as involvement. In 2015 George Fitchett was invited to address a research conference in the Netherlands on the issue of case studies. The positive response that followed had two driving factors: the desire to participate in and contribute to research, and the opportunity to be involved in research in direct proximity to the daily practice of chaplaincy. The result has been an initiative, launched in October 2016, in which 60 chaplains from various fields and 10 scholars from 4 universities participate. The scholars, most of whom supervise one of the research communities of 8 to 12 chaplains each, also meet as a research collaboration group, serving as an academic quality board for the project. Participants commit themselves for a period of four years. In that period, each chaplain will write up two case studies which, in the chaplain's own perception, are examples of good practice. On an average, each research community will produce and evaluate 20 case studies in the four-year period, aiming for a total of about 120.

The Netherlands is a secularized European country, with no more than a third of the population professing affiliation with a religious institution (25% Christian, 5% Islamic; 2% other). Forty percent professes no religious or spiritual orientation whatsoever. The remainder may consider itself to be religious (17%) or spiritual (10%) but without any formal affiliation. (Berghuijs, Pieper & Bakker 2013; Bernts & Berghuijs 2016). This diverse worldview orientation has begun to be exemplified in the Dutch association of professional chaplains Vereniging van Geestelijk VerZorgers (VGVZ). The VGVZ, with primarily chaplains from healthcare,

includes larger sections of Protestant and Catholic chaplains, small Jewish, Islamic, Buddhist and Hindu sections, but also a Humanistic section, and since 2015 a section of non-affiliated chaplains. Chaplains in government service (prison system and military) are required to have their own institutional affiliation and are generally separately organized. The chaplains in the CSP come primarily from the two Christian sections, followed by the Humanist and non-affiliated sections, with minimal participation (reflective of their numbers) from the other religious groups. The CSP includes four research communities in fields of healthcare and two in government service (military and prison system).

Phase One: Selection and methodological implications

What constitutes a case study?

A case study within the framework of the CSP on chaplaincy care is an informative story with methodical description and reflection in which the accompaniment process and the contribution of chaplaincy care are demonstrated and argued with the intent of identifying good practices.

This definition precludes other aspects of chaplaincy work such as moral deliberation or organization oriented tasks, which would require a different approach and format. The focus of the case study is on a particular, definable and empirically describable instance of chaplaincy care. The unity of the case study (Thomas 2011) lies in the specific example and practice of chaplaincy care it describes: Of what is it an example? Of the practice of chaplaincy in the care of specific persons? From there the focus can also be narrowed to chaplaincy care in a specific field, such as hospital care or the military.

In the CSP a practice is understood to be an interconnected pattern or network of observations, interactions, interventions, reflections, emotions, motivations, intentions, effects, etc. (see Reckwitz 2002.) Specifically, we focus on what chaplains do (behavior, activities, interactions, interventions), for what reasons (intentions, motivations, theoretical reasons), with what purposes (goals) and to what ends (effects, outcomes). The issue of purposes and ends is related to MacIntyre's understanding of practices as being related to some good, some striving for excellence (MacIntyre 2011). That perspective motivates the hope to identify good practices and formulate criteria for good practices, i.e., excellence. By 'good' practices we mean examples of chaplaincy care that are demonstrably representative and effective, and that are backed up by theoretical reasoning (see Kolshus et al 2013). The Dutch CPS requires in

addition confirmation by clients and other professionals, along with evaluation and recognition by experienced colleagues and researchers.

The focus of the case study, or of the CSP, is not a description of the client, patient, resident, veteran or inmate as such, the ‘living human document’ (Boisen 1936; Gerkin 1984) in need of care. The focus is on the chaplaincy care that is provided. This is not to disregard the perspective or subjectivity of the client. The good of chaplaincy care, in MacIntyre’s terms, is closely related to the goods or aims of the clients to whom care is provided. The focus of the chaplain as chaplain is and remains on the person receiving care. That is the orientation point of the case study. However, the focus of the chaplain as researcher in the CSP, and of the description in the case study, is upon his or her own practice of providing care, the interactions, the reasons, the aims, etc., and the adequacy of that care for the person in question.

The intention to identify good practices implies selection and selection criteria (See Step 1 in the Format). The first step in selection is the subjective and, at the same time, professional judgement of the chaplain who will be describing a case that involves good practice(s). The judgement is professional, in that the chaplain has reasons for that judgement based on experience and theory that will become evident in the description; the judgement is subjective, in that it has not yet been shared with and evaluated by others.

Other selection criteria have to do with various types of case studies that the literature identifies. In fact, there is a great variety of typologies to be found (Flyvbjerg 2006; Thomas 2011; Yin 2014). Thomas is critical of the notion of selecting a case study for reasons of it being *typical* or *representative*. Such labels lead to circular reasoning, rather than to an analysis on the basis of the case study itself. However, the same holds inversely for other categories that Thomas does employ, like *key case* or *outlier case*. One cannot know such matters before the case study has been completed. (Thomas also lists *local knowledge case* as a possible selection criterion, but that criterion applies to all of the cases in the CSP, inasmuch as chaplains are describing their own practice.) We therefore take such categories to be *heuristic* labels that initiate selection, but that will require re-evaluation upon completion of the case study. We take four to be helpful (which are a combination of distinctions made by Flyvbjerg (2006), Thomas (2011) and Yin (2014)): (1) *representative*, not in regard to the case study as a whole but in regard to the client population; (2) *paradigmatic*, in relation to the approach to care or style of the chaplain; (3) *outsider case*, which may be illuminating by virtue of its unusual character;

and (4) *critical case*, which can serve to test assumptions or usual ways of providing care. Formally speaking, the categories 3 and 4 could be chosen in relation to either 1 or 2 or both. More than one criterion could apply to one case.

Situating case studies in research

An underlying issue of such procedural matters is the question, what kind of evidence case studies provide? We do not locate case studies at the bottom of research hierarchies (Fitchett 2011), but take them to be a valuable form of research as such (Flyvbjerg 2006), one that seems to be on the return in other medical professions (Greenhalgh *et al.* 2016; Panter *et al.* 2016) and is particularly appropriate to chaplaincy research needs (Brown 2010; Schipani 2014. See also Veerman & Van Yperen 2007). This entails a choice for a bottom-up research approach that departs from existing professional practices in order to acquire knowledge of effective interventions. The focus lies more on the development of ‘practice based evidence’ than on evidence-based practice. The definition of the effect may be less unambiguous and the type of evidence less solid than some might wish. However, it is a type of research that can start quickly and provide evidence that is more substantial than generally thought by stacking results to more solid and more convincing evidence (Barkham, & Mellor-Clark, 2003; Veerman & Van Yperen, 2007).

Such practice-based evidence can especially arise in the framework of practice-driven evaluation, in which researchers and chaplains collaborate to describe and analyze interventions and test their effectiveness. This type of research is characterized by a close connection to the level of development of the practice, embedment in the execution of interventions and immediate application of the gathered results in practice (Veerman & Van Yperen, 2007). It can also be understood as a form of responsive research, which seeks interaction with the subject of the research (Abma, Nierse & Widdershoven, 2009; Visse, Abma, & Widdershoven, 2012). There are, in fact, three levels of interaction, one between the chaplains and their clients, one between chaplains and other involved professionals and one between the chaplains (as researchers) and the other researchers. In terms used by Abma and Stake (2014), the approach that is primarily researched in case studies is that of ‘the science of the particular’. The focus on the particular serves to clarify the complexity of the practice in question, including the meanings that people attach to events and the diffuse and often irrational elements that play a role. The value of this type is increasingly seen by other professionals (Panter *et al.* 2016; Greenhalgh *et al.* 2016; Forrester 2017). Flyvbjerg (2006)

makes clear that well executed cases studies can possess a great deal of credibility, which is a different perspective than generalizability, a concept that is based on averages rather than on the particular.

Case studies and methodology

The format of the CSP and its procedure can, of course, be useful, even if one does not subscribe to the way we understand the values of case studies. It is, however, part of the intention of the format to increase the scientific value of the case studies by means of the format and the set procedures. Checks on the (subjective) interpretation of the submitting chaplain (Riemsloagh 2011) are provided by inclusion – where possible – of recorded materials, along with descriptions of sense observations and behaviour (Step 2). In addition, feedback (comment) is requested as a form of member checking (Guba & Lincoln 1989) from the client (or client system) and from other professionals with a relation to the case. All of this contributes to triangulation (Creswell & Miller 2000), in the first place from the (*internal*) perspective of the direct environment of the case itself.

The project further enhances that value by submitting each case study to evaluation and consensus formation in a research community. To that end, the case study is written, and later discussed, in the third person form, to emphasize that the primary focus is not on the learning process of the chaplain (submitter), but on the development of the profession. The third person form assists the chaplain in understanding his or her participation in the project as that of a researcher. Although researching one's own practice as a chaplain, the focus shifts to the perspective of research.

We do not follow Yin (Yin 2014) in speaking of a case studies method. The unity of the case studies approach (Thomas 2011) lies not in a specific method, but in the application of one or more methods to the exploration and description of a specific subject matter. The description of the case by the submitting chaplain combines observation with documentation and the eliciting of feedback. The evaluation of the case in the research communities involves close reading, hermeneutical and phenomenological interpretation, as well as interpretations of the interventions of the chaplain from a variety of theoretical and discourse perspectives. This contributes to 'theoretical sensitivity' (Glaser 1978), in a continual movement back and forth between analysis of the data and the literature (Strauss & Corbin 1998).

In a dialogical process with the ethos of appreciative inquiry, some form of consensus is sought. The process includes different phases of practical theological analysis, such as *description* of the case study by the chaplain, *interpretation* and *evaluation* in the research communities, followed by the identification of *strategies* as (criteria for) good practices (see Osmer 2008), although that sounds somewhat neater than is enacted in the actual process.

The development of the profession thus becomes a cooperative effort of experienced professionals and academic researchers. This is in line with Boisen's intention, not so much a new form of theological education, but creating groups of co-researchers (Asquith 1980). That combination of focus and collaboration lies behind the choice for the term 'research community' rather than 'learning community', focused on learning processes of professionals, (Baart & Vosman 2006) or 'research group', which is the usual academic name. The CSP works with paralleled research communities, most of which specialize on a particular setting of chaplaincy care and one of which takes a comparative approach by working with mixed settings. The discussion and evaluation in the research community serves further triangulation, but now from an *external* perspective on the case study.

For the project as a whole, the usual criteria for data management are followed and application for review by a medical ethics board has been submitted (McCurdy 2015; McCurdy & Fitchett 2011). Each submitting chaplain is required to reflect upon the issues of ethical accountability and to observe the criteria of confidentiality and anonymity. Verification of the case description is included as part of that process (Step 3).

Phase Two: Description

The second phase is description of the care process by a chaplain in a specific case. In the written report, five aspects receive specific emphasis. The first is the *context* (Step 5). Besides interest in the 'living human document' (Boisen 1936) and the 'living human web' (Miller-McLemore 1996), the format requests information on institutional settings and policies, including the position and perceptions of a chaplaincy department, and the degree to which interdisciplinary communication is possible and helpful (Kestenbaum et al 2015; Schilderman 2012). In other words, the webs of institutions and of the organization of care are included in the context, for the institutional context may influence the degree of previous knowledge the chaplain has of the individual client in particular or of the client group in general. The context

can, as a result of implicit associations, also influence the type of questions put to the chaplain. Some questions might be passed off.

A second concern is to address the relation between *theory and practice* (Abu-Raiya & Pargament 2012; Slater 2015), beginning with the chaplain's profile in terms of education, training and preferences for assessment instruments and/or pastoral approaches (Step 5e). In addition, critical moments in the care process are to be described by the submitter (and later examined in the research communities) to determine what implicit and explicit (theoretical) decisions were made in the care process, for what reasons and with which results (Step 6e). This we understand as a form of *stimulated recall*, a method often used in the training of doctors, usually with the help of video recordings (Lyle 2003). More insights into the theoretical perspectives of the submitter may be gained by reconsidering at a later point the initial reasons for the selection of the case.

Related to the issues of theory and practice is the role of the *spirituality, faith convictions and ethical positions of the chaplain*. The religious background of the chaplain, along with the role of personal convictions are to be indicated (Step 5e). That information can aid the reflection on what role faith convictions actually play in the case and whether theoretical approaches or interfaith communication may be influenced by religious background (see O'Connor & Meakes 2008).

A fourth aspect is that of *describing outcomes*. (6.g.) Descriptions of outcomes are often framed in general, or spiritual (or psychological) terms. The format begins therefore with sense oriented observations and descriptions of behaviour (VandeCreek & Lucas 2001; Vandenhoeck 2007) and challenges the chaplain to be as specific and concrete as possible. The description of outcomes is then presented (along with the entire case description) to the client (or client system) and to other professionals for verification. In some instances, additional outcomes are reported in the feedback.

The specificity in reporting outcomes and the request of feedback from other professionals (Step 8) facilitates a fifth aspect, that of *communication* (Step 7). with others, the client (or client system) and other professionals regarding the care. Was charting done? Was there interdisciplinary consultation in the process? Was there reflective or evaluative communication with the client during the process?

Each case description by a chaplain is concluded by a summary statement on what the chaplain (thinks he or she) has done, for what reasons and to what ends (Step 9). The summary provides not only a final check for the chaplain, but also a succinct statement for the readers in the research community.

Phase Three: Discussion and Evaluation

Once the case study has been described and documented, it is submitted in Phase Three to a research community for discussion, clarification and evaluation. It is the task of the research community, 8 to 12 experienced chaplains under guidance of an academic researcher, to critically review the case description, explicate the implicit and identify issues for discussion.

Following questions of clarification, discussion begins with a review of the reasons for *selection* of a case for a case study. To which degree do members of the research community recognize the reasons that the submitter offers, or perhaps see other possible perspectives. No conclusion is yet drawn, as the question is taken up again at the end of the discussion and evaluation process.

The approach is thematic. It begins with a review of the basic issues, *existential aspects* (Step 11), that are central to the case. That can be expressed in a formalized term like ‘moral injury’ or in more informal descriptions like ‘loss of ...’. The attempt is then made to understand the issues in relation to the *domains of chaplaincy care*, that is, the ways in which meaning, religion or worldviews, spirituality or ethics play a role in the case. The format does not provide a definition of the domain, but instead employs a cluster of common words to refer to that domain. The various concepts serve as indicators for the domain of spirituality and world view (Meraviglia 1999). According to Polanyi, in their ‘tacit knowing’, people know more than they realize. A number of concepts or indicators function as references to a larger whole or domain, in this case that of spirituality (Polanyi 1967).

The implicit and explicit orientations and resources of the client are reviewed in order to understand how those orientations bear on the issues in the case. Then the attention shifts to the chaplain’s response to the issues in the form of interactions and interventions. Of interest, also, are the ways in which the (faith) identity of the chaplain explicitly and implicitly plays a role in that response. The emphasis does not lie in demonstrating unique contributions of a particular

religious background, as there may be a substantial overlap in convictions or values with other chaplains and their backgrounds. The point is simply to understand the influence of the convictions and persuasions of the chaplain in providing care.

Once the descriptive aspects have been clarified, there is a shift to interpreting why the chaplain has responded as he or she has, what the motivations were, especially what *theoretical* (or theological or philosophical) *perspectives* were guiding the responses, what implicit decisions were made, etc. (Step 12). This dialogical and reflective process serves to bring to the surface the tacit and practiced knowledge (Polanyi 1967; Van der Zande *et al.* 2013) of the chaplain. The initial experiences in the research communities indicate that the shared reflective practice is revealing both of a greater variety of interventions and of a greater nuance of interactions than the description or a first reading suggests. That opens up the reverse route from practice to theory, in which interventions or themes that the chaplain introduced, but that were not part of the theoretical approach, are used to comment on or add to the theory. In this manner, more differentiation in the theoretical background of the chaplain can be fostered, which in turn leads to a greater degree of integration. (In development psychology, this phenomenon is called ‘orthogenetic principle’ (Wernere & Kaplan 1956; Breeuwsma 1993).

Looking at *outcomes* (Step 13) relates the factual outcomes to the intentions and interventions of the chaplain. Here again the issues of sense observations and descriptions of behaviour, of specificity and concreteness play an important role. What observations or which feedback substantiates the described outcomes? What is the significance of any discrepancy between the factual outcomes and the intentions of the chaplains? The evaluation of a case study on moral injury revealed, for example, that the client expressed the desire to “set things right with God”, whereas the aim of the chaplain was to heal the inner wounds (Van Loenen *et al.* 2017).

Interestingly, and fortunately, both aims were met.

The research community tries to reach *consensus* (or agree to disagree) on the evaluation of the care provided (Step 14). That consensus takes on two forms: issues for further discussion or investigation and recommendations for good practices. The recommendation could take the case study as a whole as an example of good practice, or it could specify aspects of the care, criteria that emerged in the evaluation, or challenges that need to be met. It proves helpful at this point to test again the proposed reasons for selection of the case for a case study (Step 1). That verifies or alters the understanding of the information that the case provides. The

conclusion of the discussion in the research community is a brief summary (Step 15) that reformulates the summary of the chaplain (Step 9) on (a) what the chaplain has done (*description*, see Step 10 and Step 11); (b) for what reasons (*theory and practice*, see Step 12); and (c) to what ends (*outcomes*, see Step 13). This outcome may entail more or less than, or something different from what the original submitter with the case intended to demonstrate. Therefore, the discussion in the research community which results in the explication of tacit theory, identification of critical issues and the formulation of consensus substantiates the contribution of the case study to good practice.

A note could be added on the consistent use of the *third person form* in the discussions in the research communities. It takes a lot of getting used to (and some humor), accustomed as most participants are to learning contexts in which the first and second person are essential to personal formation. The initial reports by the chaplains in the research communities indicate, however, that the third person form helps them to focus on the professional aspects and conduct the evaluation in an appreciative manner.

Phase Four: Finalization

The submitter of the case study writes up the findings of the research community, with the help of notes that another member of the research community has taken. Necessary additions to the original description can be added, if the additions remain visible as such in the text. The academic researcher can help with editing the text and references for literature where appropriate. The final text is again submitted to the research community for final approval. It is the approved text that is considered to be the proper product of the collaborative work of the research community. The approved text can then be kept for later comparison, or offered for publication.

Discussion

The procedure gives rise to a number of questions.

Is the format in its thoroughness only applicable to extensive cases? Not all of the information that is asked is relevant or available in every case, but practice has shown that a single encounter of five minutes can effectively be analyzed and evaluated using the format and procedure.

Does the method provide sufficient correction to the subjective nature of the interpretations of the submitting chaplain? Never sufficiently enough, but the request for feedback from other involved parties, the use of original materials where available, the emphasis on sense observation and behaviour, and the critical questioning in the research community all serve as a counterweight. In future phases of the project, use will be made of audio and/or video recordings. Also, interviews with the involved parties (clients or those close to them, professional caregivers, etc.) may be included.

Can the process or method of arriving at criteria for and identification of good practices on the base of case studies be explicated? There is no direct path from the case study to the establishment of (criteria for) good practices. The relations between means and ends, or between interventions and outcomes, cannot be established on the basis of a single case study. The role of normative notions of chaplaincy needs clarification as well. However, the approach taken in the CSP is to first rely on recognition and consensus among the professionals in the research community, to develop theoretical perspectives on specific interventions, to look for patterns in multiple cases and to reflect upon the consensus building processes in the communities. In that sense, the project is not just about producing case studies, but is about seeking to understand how to build upon case studies to formulate criteria and practice based evidence. The project itself is open to being researched, not only with regard to the effects it has upon the professionalism of the chaplain participants, but also upon the profession as a whole.

What kind of method is needed for the sake of comparison of multiple case studies? This also is an issue that the project as a whole seeks to confront. The comparison will take different forms. One form might be to look at interventions that occur in multiple case studies. How, for example, are rituals conceived, introduced, tailored and performed? On the basis of what kind of theoretical viewpoints? Or, inversely, how does the unexpected repetition of a ritual shed light on ritual theory? Another comparison could be made, for example, of how chaplains tune into the desired outcomes of the client, how they formally or informally name, negotiate and work towards those outcomes, and to what effect. It might then be possible to abstract some criteria or strategic approaches for outcome oriented chaplaincy. The more detailed and specific the comparisons are in the beginning, the richer they will be. That raises questions on whether a general comparative method can be developed. A variety of comparative approaches may be needed. Veerman & Van Yperen (2007) provide a framework in which cases studies

and interventions are approached step by step, with the help of various methods, in order to attain a higher level of evidence: potential > plausible > functional > efficacious.

In this respect it is helpful that, whereas most of the research communities focus on one field of chaplaincy care, one community has a diversity of fields represented: rehabilitation, primary care, juvenile care, care for those with learning disabilities, general hospital. The question is how the dynamics and perspectives within that mixed community may differ from those in the one field communities.

It is, to be sure, not the intention of the CSP to just compare one case study as a whole to another case study. The concern is good practices, but not in general terms to label some practices as better than others. The idiosyncrasy of the cases is probably resistant to that. The project does aim at gathering, evaluating and comparing examples, criteria and theoretical perspectives. The cumulative effect of that process may result in the whole becoming more than the sum of the parts. The cumulative effect is dependent upon the judgement of what constitutes good qualitative research and what criteria are used to formulate the validity and credibility of the case studies. (A number of criteria can be found in Lub 2014. See also Creswell 2013; Stake 1995.)

Who is the owner of the case studies in the collaborative approach? The primary owner is the submitter. But there is also the ownership of the research community, represented for publication purposes by the academic researcher. In the third place, the CSP is owner of the case study, represented for publication by the project coordinators who are also the developers and authors of the format. The coordinators also make the case studies available to doctoral students for PhD research and to the research collaboration board for reflection on the overall processes. They also, upon request, grant permission to use the format in other projects or research activities, such as master theses. The ownership issue has two sides. One is the shared ownership in a collaborative, consensus building process. The other is the intention to uphold quality standards, not only by identifying good practices in chaplaincy care, but also by developing good research practices in the production and evaluation of case studies.

Conclusion

In the above we have sought to address two questions: (1) How can we effectively describe and evaluate practices of chaplaincy care through case studies? (2) How can we account for our

procedures and research strategies? Our way of answering those questions was, first of all, to provide an understanding of what case studies and practices are. Secondly, we investigated the variety of methods and approaches that can come to bear upon the description and analysis of case studies. In the third place, we explained the procedures of the Dutch Case Studies Project and the reasons for those procedures.

The CSP is a product of the recent surge of cases studies production in chaplaincy care, but adds several unique features which follow from the employment of the detailed standard format and procedure with extensive theoretical underpinnings. The first is the requirement of feedback from other involved parties as a first phase of triangulation from an ‘internal’ perspective. The second is the discussion and evaluation of the submitted cases studies in research communities as an integral part of the case study report. This provides a second phase of triangulation from an ‘external’ perspective. Thirdly, in both phases special attention is paid to relations between theory and practice, including the explication of tacit knowledge. A fourth feature is the way in which several research communities function in a parallel fashion, in a way that can provide material for comparative studies leading to identification of specificity in certain fields of chaplaincy care and/or common elements in various fields. By virtue of its size, differentiation and organization, the project itself can contribute to a cumulative effect. Finally, an academic advisory board of research scholars serves the project for the sake of monitoring the processes of the research and the quality of publications, as well as dealing with new theoretical and practical challenges as they arise.

The project is an expression of a shared sense of urgency among researchers and practitioners and the conviction that it is essential to the future of chaplaincy to be able to make the case for what chaplains do, for what reasons and to which ends.

Appendix: Format Dutch Case Studies Project on Chaplaincy Care

‘What do chaplains do, for what reasons and to what ends?’

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https://www.pthu.nl/Over_PThU/Organisatie/Medewerkers/m.walton/case-studies-project/

Framework

Case study

A case study is an informative story with methodical description and reflection in which the accompaniment process and the contribution of chaplaincy care are demonstrated and argued with the intent of identifying good practices.

Focus

The focus of the project and the format is that of direct contacts, individual or in group settings, between a professional chaplain and a client (or client system), including the context of the contacts. Other forms of contact, or chaplaincy care directed at organizational aspects, is equally worthy of research, but would require a different focus and format.

Format

For the sake of comparison and maximal gain a set format is employed. In light of the varying conditions of chaplaincy care in different contexts some flexibility is also required, for example in the use of terminology. The format is based upon examples in the literature and expanded upon with a view to the theoretical demands of the project. During the project, further refinement can be expected. What follows here is a framework consisting of four phases. Not all elements will be available or relevant for all cases, but it is desirable to provide as broad a variety of description and evaluation as possible and feasible. That requires careful documentation, both with regard to protection of the involved parties and with regard to the scientific quality of the research project.

Phasing

The choice of a case (Phase 1) and the description of it (Phase 2) are primarily the work of the involved chaplain, though the author could be an observer (researcher or intern). The

reflection and evaluation (Phase 3) are situated in a case studies research community, consisting of chaplains, academic researchers and other interested parties. In the completion and documentation (Phase 4) the primary author includes the results of the discussions in the research community.

The chaplain as researcher

The case study is to be written and discussed in the third person, 'he' or 'she' form. That means that the chaplain submitting a case study will write and speak about him- or herself in the third person. In the discussions of the case study in the research community all, including the author, will speak of the chaplain in the third person. In that way participation in the research community is distinct from supervision (or peer evaluation) in which personal goals and development are the focus. The primary goal of the research project is the development of the profession. *The question, for example, would not be, 'Why was I (or why were you) embarrassed by this situation?' but 'What is the effect of the embarrassment on the interaction with others in the case study?'* The role of the chaplain in the case study is initially that of a practitioner who, on the basis of her practice and with his practical experience, submits a case study. However, in the description of the case study and in the discussions in the research community, the submitting chaplain takes on the role of co-researcher.

Phase 1. Selection (Chaplain/Submitter)

1. Choosing a case

For the development of good practices, exemplary case studies are needed. It is helpful to focus on the reasons or motives for the choice of a particular case, and perhaps test those reasons in dialogue with another person, for example the academic researcher. Within the framework of research on a number of case studies, criteria of variety or specialization may influence the selection. For the choice of an individual case the following perspectives can play a role.

- a. Representative case from the patient group.
- b. Paradigmatic case of the way the chaplain works.
- c. Outsider case which, by virtue of its unusual character, is illuminating.
- d. Critical case which tests the usual way of doing things.

It is possible that the reasons or motives for the choice of a case study only really become clear at a later moment, after comparison with other case studies.

2. Materials

The case study should be written out within a month of the last contact with the client, if not earlier. At that point, additional information can have been gathered from other involved parties. In a separate document a brief list of personal data of the client is to be provided in anonymous and coded form.

In order to maintain distance to the material, the submitter (chaplain or other) will write in the third person form. The third person form emphasizes that the focus of the description is not on the learning process of the author but on the possible contribution to the development of the profession.

The material that is provided consists of:

- reporting, partly in the form of verbatims, by the chaplain;
- audio and video material of the contacts;
- feedback by others (clients, persons from the client system, other professional caregivers).

The description of Phase 2 should be limited to 6000 words, including selections from verbatims, etc., as illustrations. The maximum for the reporting on Phase 3 is 1500 words.

3. Ethical aspects

Although an individual case study is not a form of research for which approval by a medical-ethical review board is required, for the accumulation of a larger number of case studies for review and comparison approval is being sought by the project leaders. In the *description* of the cases and in the *sharing* of information, close attention must be paid to the ethical, scientific and legal frameworks of the research project.

- a. Is the description sufficiently anonymous to insure and protect confidentiality?
- b. Does that protection include not only the (primary) client, but also other involved parties?
- c. Even if *informed consent* is not formally required, is it possible to obtain the consent of the involved parties? Where such is not possible, is a written explanation demonstrating accountability provided?
- d. Has the description and interpretation of the case been checked and verified at critical points with others involved or with observing parties?

- e. Is there sufficient recognition for the role and contribution of any other involved parties?

Phase 2. Description (Chaplain/Submitter)

4. Background variables of the person(s) in question

Sex / Age / Living situation / Children / Education / Occupation / Religious or world view background / Present religion or world view / Diagnosis/Needs / Department / Size of organization / Size and composition of chaplaincy team

5. Background & context

- a. Selection: motivation to describe this particular case. What does the case make clear?
- b. Context: setting; institutional and physical surroundings.
- c. Occasion for contact: client request, professional referral, chaplain initiative, or otherwise, including prior knowledge of the chaplain.
- d. Person(s) in care: client, client system, relevant biographical information.
- e. Chaplain: age, sex, education and training, position, cultural and faith background, experience, profile professional position, other relevant antecedents, preferences.
- f. Other parties involved: who and in what manner?

6. Accompaniment process

- a. Initial contact, introduction, reason for contact
- b. Exploration of the question or situation: anamnesis, assessment, assessment instruments.
- c. Clarification of the question or situation: analysis, pastoral or spiritual diagnosis, models used.
- d. Physical observations (especially non-verbal aspects): mimicry, motoric movement, intonation, appearance, posture, eye-contact, manner in which client made contact, moods, emotional expressiveness, etc.
- e. Interactions, interventions, responses, including moments of choice and key decisions by chaplain.
- f. Chaplaincy care plan and appointments.
- g. Outcomes, results, effects:
 - sense observations of posture, attitude and behaviour;
 - reports of effects by client, client system or other professionals (caregivers);

- degree to which intended goals (e.g. bereavement processes, new perspective, improvement of relations, etc.) were realized.

7. Communication

- a. Reporting, charting, (interdisciplinary) meetings; coordination.
- b. Evaluation with any or all parties involved.

8. Reflections and feedback

- a. Reflections by the chaplain.
- b. Feedback on the description from the client or someone from the client system.
- c. Feedback on the description from one or more other professional/caregiver(s) who had contact with the client.

9. Summary

- a. What has the chaplain done (interactions, interventions, approaches)?
- b. Why and for what reasons (intentions, motivations, theoretical reasons)?
- c. What goal or goals did the chaplain have (purposes)?
- d. What was the effect (results, outcomes)?

Phase 3. Reflection & Evaluation (Case Studies Group)

10. Description

- a. Clarification. Informative questions.
- b. Observations. What does a first reading of the case offer in the way of (new) insights, promising perspectives, challenges, or critical issues for further discussion?

11. Existential aspects

- a. Existential issues. What kind of existential experiences or questions stand central?
- b. Meaning. What needs, desires or perspectives, from the point of view of religion and world view, spirituality and ethics, etc. play a role?
- c. Care process. In what manner is care provided with regard to the existential experiences and questions?
- d. Religion, faith and worldview. In which manner does the faith approach or religious identity of the chaplain play a role?

12. Relation of theory and practice

- a. What theoretical approaches were intentionally employed during the care process?
- b. What theoretical approaches or analyses emerged afterward?
- c. How did the theories work in practice, and/or what reflection on theory is possible from the viewpoint of the case in question?

13. Goals and outcomes

- a. What is the result or effect? How can that be ascertained?
- b. What was the intention of the chaplain?
- c. Was there congruency or discrepancy between (a) and (b)? What is its significance?

14. Evaluation

- a. Issues with regard to the manner and content of the care process.
- b. Issues with regard to the relation of theory and practice.
- c. Recommendations for good practices: examples, criteria, challenges.
- d. Observations on the discussions in the research community. Were there notable or critical moments during the discussion?

15. Brief summary by the research community

- a. What has the chaplain done (interactions, interventions, approaches; see 10 & 11)?
- b. Why and for what reasons (intentions, motivations, theoretical reasons; see 12)?
- c. What was the effect (results, outcomes; see 13)?
- d. What can be said retrospectively on the reasons for selection of the case study (see 1)?
- e. What would be a good title of the case study?

Phase 4. Finalizing the case study (Chaplain/submitter & research community)

16. Reporting and finalizing

- a. Someone other than the submitter takes notes on the discussion of the case study in the research community.
- b. With the help of those notes the submitter writes a report on the findings of the research community, using the framework of the points 11 to 15 of phase 3.
- c. The discussions in the research community may give occasion to altering the text of the description (phase 2) for the sake of clarification or correction. The alterations should remain visible in the text.

- d. At the next meeting of the research community, the submitter presents a complete report that includes his/her own description (phase 2) *and* the written report of the findings of the research community (phase 3).
- e. The research community establishes the definitive text of the case study.

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